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| BRANDON WOODS AT ALVAMAR | 1501 INVERNESS DR LAWRENCE, KS 66047 |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of an MDS/Staffing Focus Survey. | F 000 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This Requirement is not met as evidenced by:<br>The facility had a census of 99 residents with 10 sampled for review. Based on observation, interview, and record review, the facility failed to review/revise 5 of 10 sampled residents' nursing care plans. (#28, #25, #21, #22, and #23)<br><br>Findings included:<br><br>- Resident #28's 2/26/15 annual MDS (minimum data set) assessment revealed the resident lacked the ability to speak and had moderately | F 280 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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impaired cognition. The resident required extensive assistance of 2 persons for transfers and was dependent on 2 persons for dressing and toilet use. He/she required extensive assistance of 1 person for eating. The resident had functional limitation in range of motion on one side of both upper and lower extremities and used a wheelchair for mobility.

Resident #28's 3/5/15 Communication CAA (care area assessment) stated the resident experienced a stroke (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) in 2013 that resulted in aphasia (condition with disordered or absent language function) and paralysis (the loss of muscle function, sensation, or both) of his/her right side. The ADL (activities of daily living) CAA indicated the resident was totally dependent on staff to meet his/her needs.

Resident #28's 7/24/15 14 day Medicare MDS assessment indicated the resident had severely impaired cognition and required extensive assistance of 1 person for eating. According to the assessment, the resident swallowed without any problems and received speech therapy services.

The resident's 5/15/15 nursing care plan for incontinence directed staff to encourage fluids to prevent urinary tract infections. Review of the care plan lacked revision after a hospitalization on 7/6/15 for aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit) and after a 7/13/15 speech therapy consult that recommended a mechanical soft diet with nectar thick liquids. The care plan also lacked safe

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swallowing strategies.

Speech therapy consult on 7/13/15 indicated he/she provided the caregiver/staff education for safe swallowing strategies and recommended a mechanical soft diet with nectar thick liquids.

A dietary note dated 8/11/15 stated the resident's diet order was for a mechanical soft diet with nectar thick liquids and indicated staff fed the resident.

Review of the kardex (care guide used by direct care staff) for resident #28 stated the resident received a regular diet.

During an observation on 8/13/15 at 12:15 p.m., the resident's family member fed him/her lunch of sloppy joes, macaroni and cheese, with nectar thickened fluids of water and juice. The resident ate the meal without evidence of choking or swallowing difficulties.

During an interview on 8/13/15 at 2:51 p.m., direct care staff K stated resident #28 received thickened liquids, but does not recall any education on swallowing techniques to use while feeding the resident.

An interview on 8/13/15 at 3:14 p.m. with licensed nurse L confirmed the resident had a diagnosis of aspiration pneumonia and received thickened liquids with a mechanical soft diet after his/her hospitalization. Nurse L was unaware of any education provided regarding swallowing techniques and verified the care plan and Kardex needed updated with the correct diet.

During an interview on 8/13/15 at 4:21 p.m., administrative nurse A stated he/she expected

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staff to updated the care plan and Kardex with the current diet order for mechanical soft with nectar thick liquids and swallowing techniques to be used when feeding the resident.

The facility failed to review and revise resident #28's nursing care plan with the current diet and recommended swallowing techniques.

- Resident #25's 12/4/14 annual MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. The resident was independent with bed mobility, transfers, walking and required set up and supervision for toilet use and personal hygiene. The resident's balance was steady with no functional limitations in range of motion and used a walker for mobility. No falls occurred since the last assessment.

Resident #25's 12/15/16 ADL (activities of daily living) CAA (care area assessment) stated the resident had the ability to perform most ADLs including dressing, toileting, and grooming with supervision to limited assistance. The CAA stated the resident had a fall earlier that year when trying to place his/her blanket on the recliner.

Resident #25's 5/21/15 quarterly MDS revealed the resident had a BIMS score of 11 which indicated moderately impaired cognition. The resident was independent with set up assistance for bed mobility, transfers, walking and toilet use. The resident's balance was steady with no functional limitations in range of motion and used a walker for mobility. No falls occurred since the last assessment.

The resident's 12/16/14 nursing care plan

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indicated he/she was independent with transfers with stand by assistance at times and needed supervision with toileting. The care plan directed staff to assist him/her with dressing and to supervise when walking with the walker. The care plan instructed staff to anticipate the resident's needs like bathroom issues, assist with dressing for bed, keep call light in reach and remind the resident to call for assistance. A 7/17/15 revision directed staff to assist the resident with seating in the dining room. A revision on 8/7/15 revealed the resident had a right hip replacement and instructed staff to transfer with 2 person assistance with weight bearing as tolerated to the right lower extremity. An 8/12/15 update to the care plan directed staff to transfer with the sit to stand lift or stand pivot transfer with 2 staff.

The 8/11/15 kardex (a pocket care guide used by CNAs, certified nurse aides) indicated staff should transfer the resident with 2 person assistance, using a gait belt and pivot method.

A 7/29/15 nurses' note revealed the resident fell on 7/28/15 at 7:30 p.m. while attempting to transfer him/herself from the chair to the bed. The resident indicated his/her leg was sore, but not different than his/her usual discomfort. Staff notified the physician and the noted stated staff should use a sit to stand lift for transfers. (Review of the resident's care plan and kardex lacked revision on 7/29/15 with the change in transfer method.)

Review of nurses' notes on 8/1/15 revealed the resident denied pain. On 8/3/15 the resident had increased pain when sitting up in the wheelchair. On 8/4/15 the physician ordered an X-ray due to the resident's increase in pelvic pain. On 8/4/15

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at 5:30 p.m. the resident transferred to the hospital due to a fractured right hip. The resident returned to the facility on 8/7/15 following hip replacement surgery.

During an observation on 8/12/15 at 3:13 p.m., direct care staff N and O entered the resident's room with a sit to stand lift. Staff N and O transferred the resident from the wheelchair to the toilet with the lift. After toileting and providing personal hygiene, staff transferred the resident from the toilet to the wheelchair using the sit to stand lift. The resident tolerated with transfers without indications of discomfort.

During an interview on 8/13/15 at 2:51 p.m., direct care staff K stated prior to the resident's fall on 7/29/15 the resident was independent and required very little assistance. After the fall staff used the sit to stand lift for transfers.

An interview on 8/13/15 at 3:14 p.m. with licensed nurse L revealed resident #25 was active and ambulated independently prior to his/her fall. Nurse L verified the physician ordered sit to stand lift transfers after the fall on 7/29/15 and stated the care plan may not have been updated with the change in transfer method. Nurse L further stated the charge nurse on duty at the time of the change should update the care plan.

During an interview on 8/13/15 at 4:15 p.m., administrative nurse A stated the care plan should be updated at the time the physician ordered the change in transfer method.

The facility failed to review and revise resident #25's nursing care plan and kardex with the current method of transfer when the physician ordered for staff to use a sit to stand lift.

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- Resident #21's face sheet, revealed an admission date of 4-23-15.

Review of the admission MDS (minimum data set), dated 4-30-15, assessed the resident with a BIMS (brief interview for mental status) score of 11 indicating moderate impairment of cognitive function, no behaviors, required extensive assistance with activities of daily living, skin assessed with moisture associated skin damage, and he/she received antipsychotic medication 1 day of the 7 day look back period.

The CAA (care area assessment) for psychotropic medication use, dated 4-30-15, assessed the resident as taking an antipsychotic and an antidepressant as not new to the resident. The resident was taking Seroquel as needed for increased anxiety.

The CAA, for pressure ulcers, dated 4-30-15, assessed the resident as needing assistance with bed mobility, experienced a decline in activities of daily living and had skin maceration from urine and bowel incontinence.

The care plan, updated 7-29-15, lacked a plan addressing the resident's anxiety and interventions for use of Seroquel.

The care plan for skin problems, updated 7-29-15, lacked interventions for the skin maceration, and interventions for the open area of the sacrum, identified on 7-30-15.

The physician order sheet, dated 5-6-15, instructed staff to administer Seroquel (an antipsychotic medication), 25 milligrams, every 6 hours as needed for anxiety, ordered on 4-23-15.

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| F 280 | Continued From page 7<br><br>Observation, on 8-13-15 at 9:30 am, revealed the resident seated in the dining room, feeding him/herself breakfast. The resident finished breakfast at 11:09 am.<br><br>Observation, on 8-13-15 at 11:26 am, revealed the dressing to the resident's coccyx had loosened edges, so licensed nursing staff E provided wound care.<br><br>Interview, on 8-13-15 at 11:40 am, with administrative staff B, revealed the care plan should be updated to indicate the development of the pressure ulcer and interventions such as a turning and repositioning.<br><br>Interview, on 8-13-15 at 2:25 pm, with licensed nursing staff E, revealed staff should attempt to calm the resident without the use of medications and the interventions should be documented on the behavior monitoring sheet in the medication administration record and the care plan. At this time, staff E opened the medication administration record for the resident and noted that the behavior monitoring sheet for August 2015 was not completed and the care plan lacked identification of anxiety and interventions.<br><br>Interview, on 8-13-15 at 12:30 pm, with administrative nursing staff M, revealed Seroquel was not indicated for anxiety, and the nurses on the resident's unit should address the resident's anxiety and interventions in the care plan.<br><br>Interview, on 8-18-15 at 8:30 am, with consulting staff J, revealed the physicians who order the antipsychotic medication should identify target behaviors for staff to monitor, and anxiety was not an indication for this medication. | F 280 | | |

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| F 280 | Continued From page 8<br><br>The facility policy for psychopharmacological medication, dated 04-09-07, advise staff to provide behavior interventions for the resident.<br><br>The facility failed to review and revise the plan of care to include target behaviors for the resident's anxiety and use of Seroquel to ensure the resident received appropriate interventions for anxiety. The facility failed to review and revise the plan of care to include interventions in place for the prevention and healing of pressure ulcers.<br><br>- Review of resident #23's quarterly MDS (minimum data set), dated 7-1-15, assessed the resident with a BIMS (brief interview for mental status) of 15, indicating intact cognition, required limited assistance with toilet use, and ambulation, and extensive assistance with personal hygiene. Urinary continence was not rated due to presence of a catheter during the 7 day look back period, and the resident had a urinary tract infection in the past 30 days.<br><br>The CAA (care area assessment) for urinary tract infection, dated 1-19-15, assessed the resident with occasional urinary incontinence, able to take him/herself to the toilet but staff needed to monitor and help the resident when his/her balance, weakness and/or confusion worsened. The resident wore incontinence products.<br><br>The care plan, revised 5-22-15, advised staff of the use of a catheter due to difficulty voiding and urinary retention. Staff were to provide catheter care daily. The care plan lacked interventions to prevent traction (pulling) on the catheter, and lacked interventions for the treatment of paraphimosis (the inability to return the foreskin to its original location and balantitis ( inflammation | F 280 | | |

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of the head of the penis and the foreskin with symptoms of redness, swelling, pain, and a foul-smelling discharge).

The undated direct care staff resident care summary sheet, lacked identification of the resident's need for perineal care, retraction of the foreskin, and details regarding catheter anchoring to avoid urethral trauma.

The nurses' note dated 4-15-15, revealed the resident was seen by a urologist, who instructed staff to empty the resident's bladder by use of a straight catheter three times a day and as needed, and to keep the catheter in if the residual was greater than 500 milliliters. The resident was intermittently catheterized.

A nurses' note, dated 4-26-15, revealed the observation of blood in the resident's brief.

A nurses' note, dated 4-27-15, revealed the resident was taken to acute care for catheter removal due to pain and swelling in the penis.

A nurses' note, dated 5-5-15, revealed the resident requested a catheter for urgency.

The physician's order, dated 6-19-15, instructed staff to discontinue the Macrobid and administer Keflex (an antibiotic), 500 milligrams, four times a day, for 7 days. The physician instructed staff to support the catheter tubing to prevent the catheter from pulling on the penis.

The physician's note, dated 6-19-15, advised staff the resident had urethral erosion due to catheter traction and edema (swelling). The physician advised staff of the resident's diagnoses of balantitis and paraphimosis and need for careful

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| F 280 | Continued From page 10<br>positioning of the catheter and foreskin.<br><br>Observation, on 8-12-15 at 1:30 pm, revealed the resident seated in his/her wheelchair with the urine collection bag secured in a privacy bag. The resident declined comment about the catheter.<br><br>Interview, on 8-13-15 at 4:00 pm, with administrative nursing staff A revealed the resident should have an update to his/her care plan to alert the staff of the resident's difficulty with the leg bag, need for careful positioning, and staff should be educated on the anchoring of catheters.<br><br>The facility policy for catheter care, dated 6-30-06, advised staff to keep the catheter anchored to prevent excessive tension.<br><br>The facility failed to revise the care plan to include appropriate anchoring techniques for the resident's catheter, care of paraphimosis and balantitis to avoid pain and trauma to the penis.<br><br>- Review of resident #22's quarterly MDS (minimum data set), dated 7-8-15, assessed the resident required extensive assistance with bed mobility toilet use, dressing and personal hygiene and had an suprapubic urinary catheter.<br><br>The CAA (care area assessment) for urinary incontinence and catheter, dated 10-30-14, assessed the resident needed assistance with activities of daily living had a suprapubic catheter due to urinary retention and diagnosis of prostate cancer.<br><br>The care plan, updated 11-5-14, advised staff of the resident's suprapubic catheter and advised | F 280 | | |

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| F 280 | Continued From page 11<br>staff to provide catheter care every shift. The care plan lacked instruction on securing the catheter with an anchoring device.<br><br>Observation, on 8-13-15 at 7:35 am, revealed the resident positioned in bed. The resident's suprapubic catheter tubing lacked an anchoring device. Direct care staff D provided catheter care to the resident and stated the catheter should have an anchoring device. The resident stated he/she did not know what happened to the anchoring device, but he/she did use the bed pan during the night, and staff may have removed it at that time.<br><br>Interview, on 8-13-15 at 3:30 pm, with licensed staff E, revealed residents with catheters should have an anchoring device, and the residents with catheters no longer use leg bags, as all agreed to use the large volume urine collection bags. Staff E stated the care plan should be updated to indicate this.<br><br>The facility policy for catheter care, dated 6-30-06, advised staff to keep the catheter anchored to prevent excessive tension.<br><br>The facility failed to review and revise the care plan to include appropriate anchoring techniques of the resident's catheter to prevent stoma erosion, pain and infection. | F 280 | | |
| F 315 SS=G | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident | F 315 | | |

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who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This Requirement is not met as evidenced by:
The facility reported a census of 99 residents with 10 selected for review, which included 3 residents with urinary catheters. Based on observation, interview and record review, the facility failed to provide catheter care in a manner to prevent urethral trauma for 2 (#22 and #23) of the 3 residents reviewed for urinary catheters.

Findings included:

- Review of resident #23's quarterly MDS (minimum data set), dated 7-1-15, assessed the resident with a BIMS (brief interview for mental status) of 15, indicating intact cognition, required limited assistance with toilet use, and ambulation, and extensive assistance with personal hygiene. Urinary continence was not rated due to presence of a catheter during the 7 day look back period, and the resident had a urinary tract infection in the past 30 days.

The CAA (care area assessment) for urinary tract infection, dated 1-19-15, assessed the resident with occasional urinary incontinence, able to take him/herself to the toilet but staff needed to monitor and help the resident when his/her balance, weakness and/or confusion worsened. The resident wore incontinence products.

The care plan, revised 5-22-15, advised staff of the use of a catheter due to difficulty voiding and urinary retention. Staff were to provide catheter care daily. The care plan lacked interventions to

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| BRANDON WOODS AT ALVAMAR | 1501 INVERNESS DR LAWRENCE, KS 66047 |

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prevent traction (pulling) on the catheter, and lacked interventions for the treatment of paraphimosis (the inability to return the foreskin to its original location and balantitis ( inflammation of the head of the penis and the foreskin with symptoms of redness, swelling, pain, and a foul-smelling discharge).

The undated direct care staff resident care summary sheet, lacked identification of the resident's need for perineal care, retraction of the foreskin, and details regarding catheter anchoring to avoid urethral trauma.

Record review revealed a physician order, dated 4-2-15, which instructed staff to administer Cipro (an antibiotic), 250 milligrams, twice a day, for 14 days for the resident's statements of pain and burning with urination.

The resident developed diarrhea, per nurses' note dated 4-7-15, and elevated temperature of 100.9.

The physician order, dated 4-10-15, instructed staff to administer Diflucan(an antifungal medication) 150 milligrams, one time, and repeat in 72 hours and apply Vaseline to the resident's urethra.

The nurses' note, dated 4-12-15, indicated the resident continued with pain with urination, staff applied Nystatin (an antifungal) to the resident's groin area and continued to apply Vaseline to the urethra.

The nurses' note dated 4-15-15, revealed the resident was seen by a urologist, who instructed staff to empty the resident's bladder by use of a straight catheter three times a day and as

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needed, and to keep the catheter in if the residual was greater than 500 milliliters. The resident was intermittently catheterized.

A nurses' note, dated 4-26-15, revealed the observation of blood in the resident's brief.

A nurses' note, dated 4-27-15, revealed the resident was taken to acute care for catheter removal due to pain and swelling in the penis.

A nurses' note, dated 5-5-15, revealed the resident requested a catheter for urgency.

A nurses' note, dated 6-16-15, revealed the resident was having episodes of confusion, and bleeding from the tip of the penis.

The physician's order, dated 6-18-15, instructed staff to administer Macrobid (an antibiotic) 100 milligrams, twice a day, for 14 days.

The physician's order, dated 6-19-15, instructed staff to discontinue the Macrobid and administer Keflex (an antibiotic), 500 milligrams, four times a day, for 7 days. The physician instructed staff to support the catheter tubing to prevent the catheter from pulling on the penis.

The physician's note, dated 6-19-15, advised staff the resident had urethral erosion due to catheter traction and edema (swelling). The physician advised staff of the resident's diagnoses of balantitis and paraphimosis and need for careful positioning of the catheter.

Observation, on 8-12-15 at 1:30 pm, revealed the resident seated in his/her wheelchair with the urine collection bag secured in a privacy bag. The resident declined comment about the

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| F 315 | Continued From page 15<br>catheter.<br><br>Interview, on 8-12-15 at 4:30 pm, with direct care staff C, revealed the nurses provide catheter care, and he/she did not provide perineal care to the resident unless the resident had an incontinent episode with stool. Staff C stated the resident no longer wore a leg bag because he had pain and irritation with it. Staff C stated all residents used large volume urine collection bags and anchoring devices.<br><br>Observation, on 8-13-15 at 8:30 am, revealed direct care staff D, provided catheter care to the resident but did not retract the foreskin to cleanse the head of the penis. The resident's catheter was secured with a leg strap and attached to a large volume urine collection bag.<br><br>Interview, on 8-13-15, with staff D, revealed the resident no longer wore a leg bag as he/she developed irritation and pain and preferred to use the large volume urine collection bag.<br><br>Interview, on 8-13-15 at 3:30 pm with licensed nursing staff B, revealed the resident had a difficult time with the catheter and did have a problem with the leg bag, stating due to the resident's height. Staff B stated the catheter care was done by the nurses and was documented on the treatment sheet. Staff B stated the residents on this unit no longer used leg bags, and all the resident's agreed to use the large urine collection bags.<br><br>Interview, on 8-13-15 at 4:00 pm, with administrative nursing staff A revealed the resident should have an update to his/her care plan to alert the staff of the resident's difficulty, and staff should be educated on the anchoring of | F 315 | | |

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catheters.

Interview, on 8-14-15 at 3:30 pm, with the consulting physician G, revealed the urethral erosion occurred due to tension on the catheter due to incorrect placement of the leg bag. The physician stated the resident also had paraphimosis (strangulation of the penis due to retraction of the foreskin in an uncircumcised penis and balantitis (infection of the penis).

The facility policy for catheter care, dated 6-30-06, advised staff to keep the catheter anchored to prevent excessive tension.

The facility failed to provide appropriate anchoring of the resident's catheter resulting in urethral erosion, pain and infection.

- Review of resident #22's quarterly MDS (minimum data set), dated 7-8-15, assessed the resident required extensive assistance with bed mobility toilet use, dressing and personal hygiene and had an indwelling urinary catheter.

The CAA (care area assessment) for urinary incontinence and catheter, dated 10-30-14, assessed the resident needed assistance with activities of daily living had a suprapubic catheter due to urinary retention and diagnosis of prostate cancer.

The care plan, updated 11-5-14, advised staff of the resident's suprapubic catheter and advised staff to provide catheter care every shift. The care plan lacked instruction on securing the catheter with an anchoring device.

Observation, on 8-13-15 at 7:35 am, revealed the resident positioned in bed. The resident's

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| F 315 | Continued From page 17<br>suprapubic catheter tubing lacked an anchoring device. Direct care staff D provided catheter care to the resident and stated the catheter should have an anchoring device. The resident stated he/she did not know what happened to the anchoring device, but he/she did use the bed pan during the night, and staff may have removed it at that time.<br><br>Interview, on 8-13-15 at 3:30 pm, with licensed staff E, revealed residents with catheters should have an anchoring device, and the residents with catheters no longer use leg bags, as all agreed to use the large volume urine collection bags.<br><br>The facility policy for catheter care, dated 6-30-06, advised staff to keep the catheter anchored to prevent excessive tension.<br><br>The facility failed to provide appropriate anchoring of the resident's catheter to prevent stoma erosion, pain and infection. | F 315 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition | F 329 | | |

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| F 329 | Continued From page 18<br>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 99 residents with 10 selected for review including 2 residents selected for unnecessary medications. Based on observation, interview and record review, the facility failed to monitor effectiveness and adverse reactions to an antipsychotic medication for one (#21) of the 2 residents reviewed for unnecessary medications.<br><br>Findings included:<br><br>- Resident #21's face sheet, revealed an admission date of 4-23-15.<br><br>Review of the admission MDS (minimum data set), dated 4-30-15, assessed the resident with a BIMS (brief interview for mental status) score of 11 indicating moderate impairment of cognitive function, no behaviors, required extensive assistance with activities of daily living and received antipsychotic medication 1 day of the 7 day look back period, and diagnoses of Alzheimer's disease and depression.<br><br>The CAA (care area assessment) for psychotropic medication use, dated 4-30-15, assessed the resident as taking an antipsychotic, and antidepressant as not new to the resident. | F 329 | | |

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| F 329 | Continued From page 19 | F 329 | | |

The resident was taking Seroquel as needed for increased anxiety.

The care plan, updated 7-29-15, lacked a plan addressing the resident's anxiety and interventions for use of Seroquel.

The physician order sheet, dated 5-6-15, instructed staff to administer Seroquel (an antipsychotic medication), 25 milligrams, every 6 hours as needed for anxiety, ordered on 4-23-15.

Review of the medication administration record, for April 27, 2015, revealed the resident received Seroquel 25 mg one time for repetitive health complaints,and on May 31, 2015 for increased anxiety. The resident received Seroquel 9 times in June 2015, including 6-19: 1 dose, 6-22: 1 dose, 6-23: 2 doses, 6-24: 2 doses, 6-25: 1 dose, and 6-29: 2 doses, all administered for increased anxiety.

The nurses' note, dated 6-21-15, indicated the resident sustained a witnessed fall with head injury, on 6-21-15, and was sent to acute care for evaluation.

Review of the medication administration record, for July 2015, revealed the resident received 3 doses of Seroquel for increased anxiety.

The August 2015 medication administration record revealed the resident received 3 doses of Seroquel for increased anxiety with a dose given on 8-13-15 at 8:00 am.

The pharmacy review, dated 7-8-15, advised staff to evaluate the resident's use of Seroquel.

Review of the medical record revealed lack of

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| F 329 | Continued From page 20 | F 329 | | |

identification and monitoring of target behaviors for Seroquel from April 2015, through August 13, 2015.

Observation, on 8-12-15 at 4:45 pm, revealed the resident seated in his/her wheelchair in the dining room, attempting to move him/herself away from the table.

Observation, on 8-13-15 at 9:30 am, revealed the resident sat in the dining room, feeding him/herself breakfast. The resident finished breakfast at 11:09 am.

Interview, on 8-12-15 at 4:45 pm, with licensed nursing staff H, revealed the resident needed encouragement to eat, and generally had a good appetite. Staff H stated the resident ate slowly, and was cooperative.

Interview, on 8-12-15 at 5:45 pm, with direct care staff I, revealed the resident was cooperative with cares, and liked to watch television.

Interview, on 8-13-15 at 8:30 am, with direct care staff D, revealed the resident was cooperative with cares and was due for a shower this morning. At this time, observation revealed staff assisted the resident up in bed and transferred into his/her wheelchair, and taken to the bathroom for toileting. The resident was slow to move and cooperative with instructions.

Interview, on 8-13-15 at 2:23 pm, with direct care staff F, revealed he/she administered Seroquel 25 milligrams in the morning for anxiety, and the resident was having a bad day. Staff F stated the resident had good days and bad days and the Seroquel seemed to calm the resident.

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| F 329 | Continued From page 21<br>Interview, on 8-13-15 at 2:25 pm, with licensed nursing staff E, revealed staff should attempt to calm the resident without the use of medications and the interventions should be documented on the behavior monitoring sheet in the medication administration record. At this time, staff E opened the medication administration record for the resident and noted that the behavior monitoring sheet for August 2015 was not completed.<br><br>Interview, on 8-13-15 at 4:00 pm, with administrative nursing staff A, revealed Seroquel was not indicated for anxiety.<br><br>Interview, on 8-18-15 at 8:30 am, with consulting staff J, revealed the physicians who order the antipsychotic medication should identify target behaviors for staff to monitor, and anxiety was not an indication for this medication.<br><br>The facility policy for psychopharmacological medication, revised 4-9-07, advised staff to implement a program to ensure psychopharmacological medications and sedative /hypnotics prescribed for individual residents are clinically indicated, necessary to treat a specific condition that is diagnoses and documented in the clinical record and evaluated for continued use and monitored for adverse consequences.<br><br>The facility failed to identify and monitor this dependent, cognitively impaired resident's behaviors with the use of Seroquel, an antipsychotic medication, to prevent adverse reactions and to ensure no unnecessary medication usage for this resident. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON | F 428 | | |

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| F 428 | Continued From page 22<br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 99 residents with 10 selected for review including 2 residents selected for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure the consultant pharmacist identified drug irregularities and reported to the physician and director of nursing. The facility also failed to act upon identified irregularities related to monitoring effectiveness and adverse reactions to an antipsychotic medication for one (#21) of the 2 residents reviewed for unnecessary medications.<br><br>Findings included;<br><br>- Resident #21's face sheet, revealed an admission date of 4-23-15.<br><br>Review of the admission MDS (minimum data set), dated 4-30-15, assessed the resident with a BIMS (brief interview for mental status) score of 11 indicating moderate impairment of cognitive function, no behaviors, required extensive assistance with activities of daily living and received antipsychotic medication 1 day of the 7 day look back period, and diagnoses of Alzheimer's disease and depression. | F 428 | | |

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The CAA (care area assessment) for psychotropic medication use, dated 4-30-15, assessed the resident as taking an antipsychotic, and antidepressant as not new to the resident. The resident was taking Seroquel as needed for increased anxiety.

The care plan, updated 7-29-15, lacked a plan addressing the resident's anxiety and interventions for use of Seroquel.

The physician order sheet, dated 5-6-15, instructed staff to administer Seroquel (an antipsychotic medication), 25 milligrams, every 6 hours as needed for anxiety, originally ordered on 4-23-15.

Review of the medication administration record, for April 27, 2015, revealed the resident received Seroquel 25 mg one time for repetitive health complaints,and on May 31, 2015 for increased anxiety. The resident received Seroquel 9 times in June 2015, including 6-19: 1 dose, 6-22: 1 dose, 6-23: 2 doses, 6-24: 2 doses, 6-25: 1 dose, and 6-29: 2 doses, all administered for anxiety.

The nurses' note, dated 6-21-15, indicated the resident sustained a witnessed fall with head injury, on 6-21-15, and was sent to acute care for evaluation.

Review of the medication administration record, for July 2015, revealed the resident received 3 doses of Seroquel for increased anxiety.

The August 2015 medication administration record revealed the resident received 3 doses of Seroquel for increased anxiety with a dose given on 8-13-15 at 8:00 am.

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| F 428 | Continued From page 24<br>The pharmacy reviews, dated 5-5-15 and 6-3-15 failed to identify the facility's lack of an appropriate diagnosis for Seroquel, lack of monitoring of behaviors and adverse effects of Seroquel. The pharmacy review, dated 7-8-15, advised staff to evaluate the resident's use of Seroquel.<br><br>Review of the medical record revealed lack of identification and monitoring of target behaviors for Seroquel from April 2015, through August 13, 2015.<br><br>Observation, on 8-12-15 at 4:45 pm, revealed the resident seated in his/her wheelchair in the dining room, attempting to move him/herself away from the table.<br><br>Observation, on 8-13-15 at 9:30 am, revealed the resident seated in the dining room, feeding him/herself breakfast. The resident finished breakfast at 11:09 am.<br><br>Interview, on 8-12-15 at 4:45 pm, with licensed nursing staff H, revealed the resident needed encouragement to eat, and generally had a good appetite. Staff H stated the resident ate slowly, and was cooperative.<br><br>Interview, on 8-12-15 at 5:45 pm, with direct care staff I, revealed the resident was cooperative with cares, and liked to watch television. Observation at this time revealed staff assisted the resident up in bed and transferred into his/her wheelchair, and taken to the bathroom for toileting. The resident was slow to move and cooperative with instructions. | F 428 | | |

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| F 428 | Continued From page 25 | F 428 | | |

Interview, on 8-13-15 at 2:23 pm, with direct care staff F, revealed he/she administered Seroquel 25 milligrams in the morning for anxiety, and the resident was having a bad day. Staff F stated the resident had good days and bad days and the Seroquel seemed to calm the resident.

Interview, on 8-13-15 at 2:25 pm, with licensed nursing staff E, revealed staff should attempt to calm the resident without the use of medications and the interventions should be documented on the behavior monitoring sheet in the medication administration record. At this time, staff E opened the medication administration record for the resident and noted that the behavior monitoring sheet for August 2015 was not completed.

Interview, on 8-13-15 at 4:00 pm, with administrative nursing staff A, revealed Seroquel was not indicated for anxiety.

Interview, on 8-18-15 at 8:30 am, with consulting staff J, revealed the physicians who order the antipsychotic medication should identify target behaviors for staff to monitor, and anxiety was not an indication for this medication.

The facility policy for psychopharmacological medication, revised 4-9-07, advised staff to implement a program to ensure psychopharmacological medications and sedative /hypnotics prescribed for individual residents are clinically indicated, necessary to treat a specific condition that is diagnoses and documented in the clinical record and evaluated for continued use and monitored for adverse consequences.

The pharmacy consultant failed to identify the lack of appropriate indication for this dependent,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175277 | A. BUILDING _____ B. WING _____ | 08/20/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BRANDON WOODS AT ALVAMAR** | **1501 INVERNESS DR LAWRENCE, KS 66047** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 26<br>cognitively impaired resident's use of Seroquel, an antipsychotic medication, to prevent adverse reactions and to ensure no unnecessary medication usage for this resident. | F 428 | | |